# Applied Resolutions LLC

**An Independent Review Organization**
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/12/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Right C3-C6 Facet Medial Branch Blocks with Fluoroscopy

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified Anesthesiology/Pain Management

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 06/08/12, 06/18/12
Office visit note dated 05/10/12, 04/02/12, 03/24/12
CT head dated 03/24/12
CT cervical spine dated 03/24/12
Phone/walk-in documentation undated
Handwritten patient questionnaire undated
MRI cervical spine dated 04/10/12
Letter dated 06/22/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell on stairs, hitting the back of his head. MRI of the cervical spine dated 04/10/12 revealed no evidence of disc herniation, canal stenosis or neural foraminal encroachment at C2-3 through C5-6. At C6-7 there is a broad 1 mm disc bulge with no thecal sac stenosis or neural foraminal encroachment. Follow up note dated 05/10/12 indicates that the patient has tried physical therapy for over one month and is not getting any improvement of his pain. On physical examination deep tendon reflexes are 2+ and equal in the upper extremities.

Spurling maneuver is negative bilaterally. Strength is 5/5 throughout. There is significant tenderness to palpation over the cervical facets on the right side at C3 and C4 with some mild tenderness over the C5 facet joint.

Initial request for right C3-C6 facet medial branch blocks was non-certified on 06/08/12 noting that cervical CT scan dated xx/xx/xx showed no acute osseous abnormality of the cervical spine. No more than 2 levels may be blocked at any one time and there should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. The denial was upheld on appeal dated 06/18/12 noting that there is no elaboration of any additional clinical information or appeal correspondence from the treating provider that addresses the issues raised by the previous peer review in order to substantiate the necessity of the requested procedure.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
Based on the clinical information provided, the request for right C3-C6 facet medial branch blocks with fluoroscopy is not recommended as medically necessary, and the two previous denials are upheld. The request is excessive as the Official Disability Guidelines note that no more than 2 joint levels should be performed. The submitted CT scan dated xx/xx/xx showed no acute osseous abnormality of the cervical spine. MRI of the cervical spine dated 04/10/12 did not document any facet joint pathology. Given the current clinical data, the request is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**